



PREFERRED DRUG LIST

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ALLERGY, ASTHMA, & COPD AGENTS

Anticholinergics for the Maintenance Treatment of COPD

Preferred	Non-Preferred, Prior Authorization Required
Spiriva® Handihaler & Respimat (tiotropium)	Atrovent HFA® (ipratropium bromide) Incruse Ellipta® (umeclidinium bromide) Tudorza PressAir® (aclidinium)

Inhaled Short-Acting Beta₂-Agonists

Preferred	Non-Preferred, Prior Authorization Required
AccuNeb® (albuterol) ProAir HFA® (albuterol) ProAir RespiClick® (albuterol) Proventil HFA® (albuterol) Proventil® Inhalation Solution (albuterol) Ventolin HFA® (albuterol) Ventolin® Inhalation Solution (albuterol)	Maxair® (pirbuterol) Xopenex® Inhaltion Solution (levalbuterol) Xopenex HFA® (levalbuterol)

Inhaled Long-Acting Beta₂-Agonists

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Serevent Diskus® (salmeterol) Striverdi Respimat® (olodaterol)	Arcapta® (indacaterol) Brovana® (arformoterol) Perforomist® (formoterol)

Inhaled Long-Acting Beta₂-Agonists/Anticholinergics

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Anoro Ellipta® (umeclidinium/vilanterol) Stiolto Respimat® (tiotropium/olodaterol)	Utibron Neohaler® (indacaterol/glycopyrrolate)

Inhaled Long-Acting Beta₂-Agonists/Corticosteroids

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Advair® Diskus (fluticasone/salmeterol) Dulera® (formoterol/mometasone) Symbicort® (budesonide/formoterol)	Advair® HFA (fluticasone/salmeterol) Breo Ellipta® (fluticasone/vilanterol)

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ALLERGY, ASTHMA & COPD AGENTS (continued)

Inhaled Corticosteroids

Preferred	Non-Preferred, Prior Authorization Required
Asmanex® (mometasone)	Aerospan® (flunisolide)
Flovent® HFA (fluticasone)	Alvesco® (ciclesonide)
Pulmicort Flexhaler® (budesonide)	Arnuity Ellipta® (fluticasone)
Pulmicort Respules® (budesonide) *≤ 6 years of age only	Asmanex HFA® (mometasone)
QVAR® (beclomethasone)	Flovent® Diskus (fluticasone)
	Pulmicort Respules® (budesonide) *> 7 years of age

Intranasal Antihistamines

Preferred	Non-Preferred, Prior Authorization Required
Astelin® (azelastine)	Astepro® (azelastine) Patanase® (olopatadine)

Intranasal Corticosteroids

Preferred	Non-Preferred, Prior Authorization Required
Flonase® (fluticasone)	Beconase AQ® (beclomethasone)
Qnasl® (beclomethasone)	Nasacort AQ®(triamcinolone) Nasarel® (flunisolide) Nasonex® (mometasone) Omnaris® (ciclesonide) Rhinocort AQ® (budesonide) Veramyst® (fluticasone) Zetonna® (ciclesonide)

Non-Sedating Antihistamines

Preferred	Non-Preferred, Prior Authorization Required
Claritin® (loratadine) Claritin 24-hr Allergy® (loratadine) Claritin® Syrup (loratadine) Zyrtec® (cetirizine) Zyrtec® Syrup (cetirizine)	Allegra® (fexofenadine) Allegra® ODT (fexofenadine) Clarinex® (desloratadine) Claritin Hives Relief® (loratadine) Claritin RediTabs® (loratadine) Xyzal® (levocetirizine) The following drugs are covered for KBH only: Allegra-D® (fexofenadine/pseudoephedrine) Allegra-D24® (fexofenadine/pseudoephedrine) Clarinex-D 12-hour® (desloratadine/pseudoephedrine) Clarinex-D 24-hour® (desloratadine/pseudoephedrine)

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ALLERGY, ASTHMA & COPD AGENTS (continued)

Ophthalmic Antihistamine/Mast Cell Stabilizer Combinations

Preferred	Non-Preferred, Prior Authorization Required
Alaway® (ketotifen)	Alocril® (nedocromil)
Cromolyn® (cromolyn)	Bepreve® (bepotastine)
Patanol® (olopatadine)	Elestat® (epinastine)
Pazeo® (olopatadine)	Lastacaft® (alcaftadine)
Refresh® (ketotifen)	Optivar® (azelastine)
Zaditor® (ketotifen)	Pataday® (olopatadine)

ANALGESICS

Long-Acting Opioids

Preferred	Non-Preferred-Prior Authorization Required
Duragesic® (fentanyl)	Avinza® (morphine sulfate ER)
Embeda® (morphine/naltrexone)	Belbuca® (buprenorphine)
MS Contin® (morphine sulfate ER)	Butrans® (buprenorphine)
OxyContin® (oxycodone SR)	ConZip® (tramadol)
Ultram ER® (tramadol ER)	Exalgo® (hydromorphone HCl ER)
	Hysingla ER® (hydrocodone ER)
	Kadian® (morphine sulfate ER)
	Nucynta ER® (tapentadol)
	Opana ER® (oxymorphone)
	Ryzolt® (tramadol ER)
	Zohydro ER® (hydrocodone bitartrate ER)

Muscle Relaxants (Skeletal)

Preferred	Non-Preferred, Prior Authorization Required
Flexeril® (cyclobenzaprine)	Amrix® (cyclobenzaprine ER)
Robaxin® (methocarbamol)	Fexmid® 7.5mg (cyclobenzaprine)
Robaxin-750® (methocarbamol)	Lorzone® (chlorzoxazone)
	Norflex® (orphenadrine)
	Norgesic® (orphenadrine/aspirin/caffeine)
	Norgesic® Forte (orphenadrine/aspirin/caffeine)
	Parafon Forte DSC® (chlorzoxazone)
	Skelaxin® (metaxalone)

Muscle Relaxants (Spasticity)

Preferred	Non-Preferred, Prior Authorization Required
Lioresal® (baclofen)	Dantrolene® (dantrolene)
Zanaflex® Tablets (tizanidine)	Zanaflex® Capsules (tizanidine)



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ANALGESICS (continued)

Non-Steroidal Anti-Inflammatory Drugs (Ophthalmic)

Preferred	Non-Preferred, Prior Authorization Required
Acular® (ketorolac)	Acular LS® (ketorolac)
Ilevro® (nepafenac)	Acuvail® (ketorolac)
Nevanac® (nepafenac)	Bromday® (bromfenac)
Ocufen®(flurbiprofen)	Prolensa® (bromfenac)
Voltaren® Ophthalmic (diclofenac)	

Non-Steroidal Anti-Inflammatory Drugs (Topical)

Preferred	Non-Preferred, Prior Authorization Required
Flector® Patch (diclofenac epolamine)	Pennsaid® (diclofenac)
Voltaren® Gel (diclofenac)	Srix® Nasal Spray (ketorolac tromethamine)

Non-Steroidal Anti-Inflammatory Drugs (Oral)

Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Advil® (ibuprofen)	Anaprox® (naproxen)
Aleve® (naproxen)	Anaprox DS® (naproxen)
Ansaid® (flurbiprofen)	Arthrotec® (diclofenac/misoprostol)
Cataflam® (diclofenac potassium)	Cambia® (diclofenac)
Clinoril® (sulindac)	Daypro® (oxaprozin)
EC-Naprosyn® (naproxen)	Dolobid® (diflunisal)
Indocin® (indomethacin)	Feldene® (piroxicam)
Mobic® (meloxicam)	Indocin® SR (indomethacin)
Motrin® (ibuprofen)	Lodine® (etodolac)
Motrin-IB® (ibuprofen)	Lodine® XL (etodolac)
Naprosyn® (naproxen)	Meclofenemate® (meclofenamate)
Relafen® (nabumetone)	Nalfon® (fenoprofen)
Toradol®(ketorolac) (limited to a 5 day supply)	Naprelan® (naproxen)
Voltaren®(diclofenac sodium oral)	Naprelan® CR Dosepak (naproxen)
Voltaren® XR (diclofenac sodium oral)	Orudis® (ketoprofen)
	Orudis® KT (ketoprofen)
	Oruvail® (ketoprofen)
	Ponstel® (mefenamic acid)
	Tivorbex® (indomethacin)
	Tolectin 600® (tolmetin)
	Tolectin DS® (tolmetin)
	Vimovo®(naproxen/esomeprazole)
	Zipsor® (diclofenac)
	Zorvolex® (diclofenac)

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ANALGESICS (continued)

COX-II Inhibitors

Preferred	Non-Preferred
Celebrex® (celecoxib)	

Triptans

Preferred	Non-Preferred, Prior Authorization Required
Imitrex® (sumatriptan) tablets	Alsuma® (sumatriptan)
Maxalt® (rizatriptan)	Amerge® (naratriptan)
Maxalt-MLT® (rizatriptan)	Axert® (almotriptan)
Relpax® (eletriptan)	Frova® (frovatriptan)
	Imitrex® (sumatriptan) pens, vials, cartridges, nasal spray
	Sumavel DosePro® (sumatriptan)
	Zecuity® (sumatriptan)
	Zomig® (zolmitriptan)
	Zomig-ZMT® (zolmitriptan)

ANTICOAGULANTS

Anticoagulants

Preferred	Non-Preferred, Prior Authorization Required
Coumadin® (warfarin)	Savaysa® (edoxaban)
Eliquis® (apixaban)	
Pradaxa® (dabigatran)	
Xarelto® (rivaroxaban)	

ANTIHYPERLIPIDEMICS

Bile Acid Sequestrants

Preferred	Non-Preferred, Prior Authorization Required
Colestid® Tablets (colestipol)	Colestid® Granules (colestipol)
Questran Light® (cholestyramine light)	Prevalite® Powder (cholestyramine light)
Welchol® Powder (colesevelam)	Prevalite® Powder Packs (cholestyramine light)

Combination Products for Hyperlipidemia

Preferred	Non-Preferred
Vytorin® (ezetimibe/simvastatin)	

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ANTIHYPOLIPIDEMICS (continued)

Fibric Acid Derivatives

Preferred	Non-Preferred, Prior Authorization Required
Fenofibrate generics Lopid® (gemfibrozil)	Antara® (fenofibrate) Fenoglide® (fenofibrate) Lipopen® (fenofibrate) Lofibra® (fenofibrate) Tricor® (fenofibrate) Triglide® (fenofibrate) Trilipix® (fenofibric acid)

HMG-CoA Reductase Inhibitors (Statins)

Preferred	Non-Preferred, Prior Authorization Required
Lipitor® (atorvastatin)	Altoprev® (lovastatin)
Mevacor® (lovastatin)	Crestor® (rosuvastatin)
Pravachol® (pravastatin)	Lescol® (fluvastatin)
Zocor® (simvastatin)	Lescol XL® (fluvastatin) Livalo® (pitavastatin)

Homozygous Familial Hypercholesterolemia (HoFH) Agents

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Kynamro® (mipomersen)	Juxtapid® (lomitapide mesylate)

Hypertriglyceridemia Agents

Preferred	Non-Preferred, Prior Authorization Required
Lovaza® (omega-3 acid ethyl esters)	Vascepa® (icosapent ethyl)

ANTI-INFECTIVES

Inhaled Tobramycin Products

Preferred	Non-Preferred, Prior Authorization Required
Bethkis® (tobramycin) Tobi® (tobramycin)	Tobi Podhaler® (tobramycin)



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ANTIVIRAL AGENTS

Antiherpes Virus Agents

Preferred	Non-Preferred, Prior Authorization Required
Valtrex® (valacyclovir)	Famvir® (famciclovir)
Zovirax® (acyclovir) (oral dosage forms only)	

Hepatitis C Antiviral Agents

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Zepatier® (elbasvir/grazoprevir)	Daklinza® (daclatasvir) Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir)/Olysio® (simplicavir) in combination Technivie® (ombitasvir/paritaprev/ritonavir) Viekira Pak® (dasabuvir/ombitasvir/paritaprev/ritonavir)

Hepatitis C Protease Inhibitors

**Clinical prior authorization may apply*

Preferred	Non-Preferred
Victrelis® (boceprevir)	

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BIOLOGICS

Agents to Treat Adult Rheumatoid Arthritis

**Clinical prior authorization may apply*

Injectable

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Actemra® (tocilizumab) Cimzia® (certolizumab) Kineret® (anakinra) Orencia® (abatacept) Remicade® (infliximab) Rituxan® (rituximab) Simponi® (golimumab)

Oral

Preferred	Non-Preferred
Xeljanz® (tofacitinib)	

Agents to Treat Ankylosing Spondylitis

**Clinical prior authorization may apply*

Injectable

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Remicade® (infliximab) Simponi® (golimumab)

Agents to Treat Crohn's Disease

**Clinical prior authorization may apply*

Injectable

Preferred	Non-Preferred, Prior Authorization Required
Humira® (adalimumab)	Cimzia® (certolizumab) Remicade® (infliximab) Tysabri® (natalizumab)

Agents to Treat Juvenile Idiopathic Arthritis

**Clinical prior authorization may apply*

Injectable

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Actemra® (tocilizumab) Orencia® (abatacept)

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BIOLOGICS (continued)

Agents to Treat Plaque Psoriasis

**Clinical prior authorization may apply*

Injectable

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Amevive® (alefacept) Cosentyx® (secukinumab) Remicade® (infliximab) Stelara® (ustekinumab)

Oral

Preferred	Non-Preferred
Otezla® (apremilast)	

Agents to Treat Psoriatic Arthritis

**Clinical prior authorization may apply*

Injectable

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Remicade® (infliximab) Simponi® (golimumab) Stelara® (ustekinumab)

Oral

Preferred	Non-Preferred
Otezla® (apremilast)	

Agents to Treat Ulcerative Colitis

**Clinical prior authorization may apply*

Injectable

Preferred	Non-Preferred, Prior Authorization Required
Humira® (adalimumab)	Remicade® (infliximab)

CARDIOVASCULAR AGENTS

ACE Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Accupril® (quinapril)	Aceon® (perindopril)
Altace® (ramipril)	Capoten® (captopril)
Lotensin® (benazepril)	Epaned® (enalapril solution)
Monopril® (fosinopril)	Mavik® (trandolapril)
Prinivil® (lisinopril)	Univasc® (moexipril)
Zestril® (lisinopril)	Vasotec® (enalapril)



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CARDIOVASCULAR AGENTS (continued)

ACE Inhibitor/Calcium Channel Blocker Combinations

Preferred	Non-Preferred, Prior Authorization Required
Lotrel® (benazepril/amlodipine)	Tarka® (trandolapril/verapamil)

ARBs

Preferred	Non-Preferred, Prior Authorization Required
Avalide® (irbesartan/HCTZ)	Atacand® (candesartan)
Avapro® (irbesartan)	Atacand HCT® (candesartan/HCTZ)
Benicar® (olmesartan)	Edarbi® (azilsartan medoxomil)
Benicar HCT® (olmesartan/HCTZ)	Micardis® (telmisartan)
Cozaar® (losartan)	Micardis HCT® (telmisartan/HCTZ)
Diovan® (valsartan)	Teveten® (eprosartan)
Diovan HCT® (valsartan/HCTZ)	
Hyzaar® (losartan/HCTZ)	

ARB/Calcium Channel Blocker Combinations

Preferred	Non-Preferred, Prior Authorization Required
Azor® (amlodipine/olmesartan)	Twynsta® (amlodipine/telmisartan)
Exforge® (amlodipine/valsartan)	

Beta-Blockers

Preferred	Non-Preferred, Prior Authorization Required
Betapace® (sotalol)	Blocadren® (timolol)
Betapace AF® (sotalol AF)	Bystolic® (nebivolol)
Coreg® (carvedilol)	Coreg CR® (carvedilol CR)
Inderal® (propranolol)	Corgard® (nadolol)
Lopressor® (metoprolol tartrate)	Inderal® LA (propranolol XL)
Sectral® (acebutolol)	InnoPran® XL (propranolol XL)
Tenormin® (atenolol)	Kerlone® (betaxolol)
	Labetalol (labetalol)
	Levatol® (penbutolol)
	Toprol® XL (metoprolol succinate)
	Visken® (pindolol)
	Zebeta® (bisoprolol)

Calcium Channel Blockers (Dihydropyridines)

Preferred	Non-Preferred, Prior Authorization Required
Adalat CC® (nifedipine ER)	Adalat® (nifedipine IR)
Norvasc® (amlodipine)	Cardene® (nicardipine IR)
Plendil® (felodipine)	Cardene® SR (nicardipine SR)
Procardia® XL (nifedipine ER)	DynaCirc® (isradipine IR)
	Sular® (nisoldipine)



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CARDIOVASCULAR AGENTS (continued)

Calcium Channel Blockers (Non-Dihydropyridines)

Preferred	Non-Preferred, Prior Authorization Required
Calan® (verapamil IR)	Cardizem CD® (diltiazem)
Calan SR® (verapamil SR)	Cardizem LA® (diltiazem)
Cardizem® (diltiazem IR)	Cardizem SR® (diltiazem)
Dilt-XR® (diltiazem ER)	Cartia XT® (diltiazem ER)
Isoptin SR® (verapamil SR)	Matzim LA® (diltiazem ER)
Taztia XT® (diltiazem ER)	Verelan® (verapamil SR)
Tiazac® (diltiazem)	Verelan PM® (verapamil)

CENTRAL NERVOUS SYSTEM AGENTS

Adjunct Antiepileptics

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Keppra® (levetiracetam)	Banzel® (rufinamide)
Keppra® XR (levetiracetam XR)	Briviact® (brivaracetam)
Lyrica® (pregabalin)	Fycompa® (perampanel)
Neurontin® (gabapentin)	Gabitril® (tiagabine)
Zonegran® (zonisamide)	Onfi® (clobazam)
	Oxtellar XR® (oxcarbazepine)
	Potiga® (ezogabine)

Non-Benzodiazepine Sedative Hypnotics

Preferred	Non-Preferred, Prior Authorization Required
Ambien® (zolpidem)	Ambien® CR (zolpidem CR)
Zolpidem generics	Belsomra® (suvorexant)
	Edluar® (zolpidem)
	Intermezzo® (zolpidem)
	Lunesta® (eszopiclone)
	Sonata® (zaleplon)

Non-Scheduled Novel Sleep Agents

Preferred	Non-Preferred
Rozerem® (ramelteon)	

DIABETIC AGENTS

AlphaGlucosidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Glyset® (miglitol)	
Precose® (acarbose)	

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DIABETIC AGENTS (continued)

Biguanides

Preferred	Non-Preferred, Prior Authorization Required
Glucophage® (metformin)	Fortamet® (metformin ER)
Glucophage® XR (metformin ER)	Glumetza® (metformin ER) Riomet® (metformin oral solution)

Dipeptidyl Peptidase-4 Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Januvia® (sitagliptin)	Nesina® (alogliptin)
Onglyza® (saxagliptin)	Tradjenta® (linagliptin)

Incretin Mimetics

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Bydureon® Pens and Vials (exenatide ER)	Tanzeum® (albiglutide)
Byetta® (exenatide)	Trulicity® (dulaglutide)
Victoza® (liraglutide)	

Insulin Delivery Systems

Preferred	Non-Preferred, Prior Authorization Required
Humalog® multi-dose vial	Humalog® (excluding multi-dose vials)
Humalog® Mix multi-dose vial	Humalog® Mix (excluding multi-dose vials)
Humulin N® multi-dose vial	Humulin N® (excluding multi-dose vials)
Humulin R® multi-dose vial	Humulin R® (excluding multi-dose vials)
Humulin 70/30® multi-dose vial	Humulin 70/30® (excluding multi-dose vials)
Novolin N® multi-dose vial	Novolin N® (excluding multi-dose vials)
Novolin R® multi-dose vial	Novolin R® (excluding multi-dose vials)
Novolin 70/30® multi-dose vial	Novolin 70/30® (excluding multi-dose vials)
NovoLog® multi-dose vial, PenFill, & FlexPen	Velosulin BR® (excluding multi-dose vials)
NovoLog® Mix multi-dose vial, PenFill, & FlexPens	
Velosulin BR® multi-dose vial	

Long-Acting Insulin

Preferred	Non-Preferred, Prior Authorization Required
Lantus® (insulin glargine)	Toujeo Solostar® (insulin glargine)
Lantus SoloStar® (insulin glargine)	Tresiba FlexTouch® (insulin degludec)
Levemir® Vial, FlexPen, FlexTouch (insulin detemir)	

Meglitinides

Preferred	Non-Preferred, Prior Authorization Required
Prandin® (repaglinide)	
Starlix® (nateglinide)	

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DIABETIC AGENTS (continued)

2nd Generation Sulfonylureas

Preferred	Non-Preferred, Prior Authorization Required
Amaryl® (glimepiride)	Glucotrol XL® (glipizide XL)
DiaBeta® (glyburide)	Metaglip® (glipizide/metformin)
Glucotrol® (glipizide)	
Glucovance® (glyburide/metformin)	
Glynase PresTab® (micronized glyburide)	
Micronase® (glyburide)	

Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Invokana® (canagliflozin)	Faxigya® (dapagliflozin)
	Jardiance® (empagliflozin)

Thiazolidinediones

Preferred	Non-Preferred, Prior Authorization Required
Actos® (pioglitazone)	ACTOplus Met XR® (pioglitazone/metformin)
ACTOplus Met® (pioglitazone/metformin)	Avandamet® (rosiglitazone/metformin)
	Avandia® (rosiglitazone)
	Duetact® (pioglitazone/glimepiride)

GASTROINTESTINAL AGENTS

Cannabinoid Antiemetics

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Marinol® (dronabinol)	Cesamet® (nabilone)

H₂ Antagonists

Preferred	Non-Preferred, Prior Authorization Required
Pepcid® (famotidine)	Axid® (nizatidine)
Zantac® (ranitidine)	Pepcid® (famotidine) oral suspension
	Tagamet® (cimetidine)

Oral Mesalamine Products

Preferred	Non-Preferred, Prior Authorization Required
Apriso® (mesalamine ER 24hr)	Asacol HD® (mesalamine DR)
Delzicol® (mesalamine DR)	Lialda® (mesalamine DR)
Pentasa® (mesalamine ER)	



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GASTROINTESTINAL AGENTS (continued)

Pancreatic Enzyme Replacements

Preferred	Non-Preferred, Prior Authorization Required
Creon® (pancrelipase)	Pertzye® (pancrelipase)
Pancreaze® (pancrelipase)	Viokace® (pancrelipase)
Zenpep® (pancrelipase)	

Proton Pump Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Prilosec® (omeprazole)	AcipHex® (rabeprazole)
Protonix® (pantoprazole)	AcipHex® Sprinkles (rabeprazole)
	Dexilant® (dexlansoprazole)
	Esomeprazole strontium® (esomeprazole strontium)
	Nexium® (esomeprazole)
	Nexium® Suspension (esomeprazole)
	Prevacid® (lansoprazole)
	Prevacid SoluTab® (lansoprazole)
	Prilosec® Packets (omeprazole)

Serotonin 5HT₃ Antagonists

Preferred	Non-Preferred, Prior Authorization Required
Zofran® (ondansetron)	Anzemet® (dolasetron)
Zofran ODT® (ondansetron)	Gransol® (granisetron)
	Kytril® (granisetron)
	Sancuso® (granisetron)
	Zuplenz® (ondansetron)

GOUT AGENTS

Xanthine Oxidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Zyloprim® (allopurinol)	Uloric® (febuxostat)

INJECTABLES

Anaphylaxis Agents

Preferred	Non-Preferred, Prior Authorization Required
Epipen® (epinephrine auto inject)	Adrenaclick® (epinephrine auto inject)
Epipen Jr® (epinephrine auto inject)	Epinephrine auto injectors

Erythropoiesis-Stimulating Agents

Preferred	Non-Preferred, Prior Authorization Required
Epogen® (epoetin alfa)	Aranesp® (darbepoetin alfa)
Procrit® (epoetin alfa)	

PREFERRED DRUG LIST

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INJECTABLES (continued)

Growth Hormones

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Genotropin® (somatropin)	Humatrope® (somatropin)
Genotropin® MiniQuick (somatropin)	Nutropin® AQ (somatropin)
Norditropin® FlexPro (somatropin)	Nutropin AQ NuSpin® (somatropin)
Omnitrope® (somatropin)	Saizen® (somatropin)
	Zomacton® (somatropin)

Injectable Methotrexate

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Rasuvo® (methotrexate)	Otrexup® (methotrexate)

OPHTHALMIC AGENTS

Ophthalmic Anti-Infective/Steroid Combinations

Preferred	Non-Preferred, Prior Authorization Required
Blephamide® (sulfacetamide/prednisolone)	Blephamide S.O.P.® (sulfacetamide/prednisolone)
Maxitrol® (neomycin/polymyxin/dexamethasone)	TobraDex® (tobramycin/dexamethasone)
Pred-G® (prednisolone/gentamicin)	TobraDex ST® (tobramycin/dexamethasone)
Pred-G S.O.P.® (prednisolone/Gentamicin)	

Ophthalmic Prostaglandin Analogs

Preferred	Non-Preferred, Prior Authorization Required
Xalatan® (latanoprost)	Lumigan® (bimatoprost) Travatan Z® (travoprost) Zioptan® (tafluprost)

Carbonic Anhydrase Inhibitors

Preferred	Non-Preferred
Azopt® (brinzolamide)	
Simbrinza® (brinzolamide/brimonidine tartrate)	
Trusopt® (dorzolamide)	

OPIOID-INDUCED CONSTIPATION AGENTS

Opioid-Induced Constipation Agents

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Movantik® (naloxegol)	Relistor® (methylnaltrexone)



PREFERRED DRUG LIST

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OSTEOPOROSIS AGENTS

Bisphosphonates

Preferred	Non-Preferred, Prior Authorization Required
Fosamax® (alendronate)	Actonel® (risedronate) Atelvia® (risedronate) Binosto® (alendronate) Boniva® (ibandronate) Fosamax Plus D® (alendronate/cholecalciferol)

OTIC COMBINATIONS

Otic Anti-Infective/Steroid Combinations

Preferred	Non-Preferred, Prior Authorization Required
Cipro HC® (ciprofloxacin/hydrocortisone)	Acetasol HC® (acetic acid/hydrocortisone)
Ciprodex® (ciprofloxacin/dexameth)	Cortisporin® Otic Suspension (neomycin/polymyxin B/hc)
Cortisporin® Otic Solution (neomycin/polymyxin B/hc)	Cortisporin-TC® (neomy/colist/hc/thonz)

PCSK – 9 INHIBITORS

PCSK-9 Inhibitors

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Repatha® (evolocumab)	Praluent® (alirocumab)

PHOSPHATE BINDER AGENTS

Phosphate Binder Agents

Preferred	Non-Preferred, Prior Authorization Required
Eliphos® (calcium acetate) Phoslo® (calcium acetate)	Auryxia® (ferric citrate) Fosrenol® (lanthanum carbonate) Phoslyra® (calcium acetate oral solution) Renagel® (sevelamer HCl) Renvela® (sevelamer carbonate) Velphoro® (sucroferric oxyhydroxide)

PLATELET AGGREGATION INHIBITORS

Platelet Aggregation Inhibitors - Stroke

Preferred	Non-Preferred, Prior Authorization Required
Plavix® (clopidogrel)	Aggrenox® (aspirin-dipyridamole ER)

Platelet Aggregation Inhibitors - Secondary Cardiac Prevention

Preferred	Non-Preferred, Prior Authorization Required
Plavix® (clopidogrel)	Brilinta® (ticagrelor) Effient® (prasugrel) Zontivity® (vorapaxar)

PREFERRED DRUG LIST

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THROMBOPOIETIN (TPO) RECEPTOR AGONISTS

Thrombopoietin (TPO) Receptor Agonists

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Nplate® (romiplostim)	Promacta® (eltrombopag)

TOPICAL ACNE AGENTS

Topical Acne Agents

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Acanya® (benzoyl peroxide-clindamycin) gel	Avar® (sulfacetamide-sulfur) pads
Aczone® (dapsone) gel	Avar-E® Emollient (sulfacetamide-sulfur) cream
Atralin® (tretinoin) gel	Avar-E Green® (sulfacetamide-sulfur) cream
Avita® (tretinoin) cream	Avar LS® (sulfacetamide-sulfur) pads
Azealex® (azelaic acid) cream	Benzacln® (benzoyl peroxide-clindamycin) gel
Cerisa® (sulfacetamide-sulfur) emulsion	Benzamycin® (benzoyl peroxide-erythromycin) gel
Cleocin-T® (clindamycin) lotion	Clindacin ETZ® (clindamycin) swab
Cleocin-T® (clindamycin) solution	Differin® (adapalene) cream
Clindacin-P® (clindamycin) swab	Differin® (adapalene) gel
Clindagel® (clindamycin) gel	Duac® (benzoyl peroxide-clindamycin) gel
Epiduo® (benzoyl peroxide-adapalene) gel	Epiduo Forte® (adapalene/benzoyl peroxide)
Ery® (erythromycin) pads	Erygel® (erythromycin) gel
Erythromycin solution	Evoclin® (clindamycin phosphate) foam
Onexton® (benzoyl peroxide-clindamycin) gel	Fabior® (tazarotene) foam
Retin-A® (tretinoin) cream	Klaron® (sulfacetamide) lotion
SSS 10-5® (sulfacetamide-sulfur) cream	Neuac® (clindamycin/benzoyl peroxide)
Sulfacetamide suspension	Retin-A® Micro (tretinoin) gel
Sulfacetamide-Sulfur lotion	Rosanil® Cleanser (sulfacetamide-sulfur) emulsion
Tazorac® (tazarotene) cream	Rosula® (sulfacetamide-sulfur) pads
Tazorac® (tazarotene) gel	Sumadan® (sulfacetamide-sulfur) kit
Zencia® (sulfacetamide-sulfur) liquid	Sumadan® Wash (sulfacetamide-sulfur) liquid
Ziana® (clindamycin-tretinoin)	Sumaxin® (sulfacetamide-sulfur) pads
	Sumaxin TS® (sulfacetamide-sulfur) suspension
	Sumaxin® Wash (sulfacetamide-sulfur) liquid
	Veltin® (clindamycin-tretinoin)

TOPICAL LICE TREATMENTS

Topical Lice Treatments

Preferred	Non-Preferred, Prior Authorization Required
Sklice® (ivermectin)	Natroba® (spinosad) Ovide® (malathion)



PREFERRED DRUG LIST

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TOPICAL TESTOSTERONE AGENTS

Topical Testosterone Agents

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Androderm® (testosterone)	Fortesta® (testosterone)
Androgel® (testosterone)	Testim® (testosterone)
Axiron® (testosterone)	Vogelxo® (testosterone)

UROLOGIC AGENTS

Anticholinergics

Preferred	Non-Preferred, Prior Authorization Required
Ditropan® (oxybutynin)	Detrol® (tolterodine)
Ditropan XL® (oxybutynin ER)	Detrol® LA (tolterodine ER)
Enablex® (darifenacin)	Gelnique® Gel (oxybutynin)
Toviaz® (fesoterodine)	Oxytrol® Patch (oxybutynin)
Vesicare® (solifenacina)	Sanctura® (trospium)
	Sanctura XR® (trospium ER)
	Urispas® (flavoxate)

Beta-3 Adrenergic Agonists

Preferred	Non-Preferred
Myrbetriq®(mirabegron)	